IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

July 1, 2008

Mary Detienne
Panhandle Health District
8500 North Atlas Road
Hayden, Idaho 83835

RE: Panhandle Health District, provider #137002

Dear Ms. Deteinne:

This is to advise you of the findings of the Medicare survey at Panhandle Health District which was concluded on June 5, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **July 14, 2008**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

Patricia O'Hara

PATRICIA O'HARA
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PO/mlw

Enclosures

PANHANDLE HEALTH DISTRICT

Healthy People in Healthy Communities

8500 N. ATLAS ROAD
HAYDEN, IDAHO 83835
http://www2.state.id.us/phd1

Public Health

July 10, 2008

Sylvia Creswell
Co-Supervisor
Non-Long Term Care
Bureau of Facility Standards
P.O. Box 83720
Boise, Id. 83720-0036

RE: Panhandle Health District, provider # 137002

Dear Ms. Creswell:

Enclosed please find the plan of correction for the survey completed the week of June 02, 2008. On behalf of my staff and the contractors who worked with Patricia O'Hara and Patrick Hendrickson, I would like to thank them for the professional manner with which they conducted the survey. Though we always remain in "ready" mode for a site visit, nonetheless there is an element of stress that accompanies these surveys. Patricia and Patrick conducted the survey with professionalism, collaboration and a spirit of cooperation that helped ease staff anxiety. Their approach fostered a learning atmosphere which I believe aids in our understanding and application of the conditions of participation.

Please feel free to contact me with any questions/concerns that you may have as you review this plan of correction.

Our goal is to continue to excellent patient care as we serve the residents of North Idaho with Home Health care services.

Thank you.

Sincerely yours,

Mary DeTienne, BA, R.N.
Home Health Division Administrator
Panhandle Health District I

Enc.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137002	A. BUILDING _____ B. WING _____	06/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANHANDLE HEALTH DISTRICT	8500 N ATLAS ROAD HAYDEN, ID 83835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES I (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	'PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your agency. The surveyors conducting the recertification survey were: Patricia O'Hara, RN, HFS, Team Leader, Patrick Hendrickson, RN, HFS Acronyms used in this report: PT - Physical Therapy OT - Occupational Therapy SOC - Start of Care POC- Plan of Care SN - Skilled Nursing HHA - Home Health Agency MD - Medical Doctor	G 000	RECEIVED JUL 14 2008 FACILITY STANDARDS	
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, I reporting, and coordination of patient care does occur. This STANDARD is not m et as evidenced by: Based on record review it was determined that the HHA failed to ensure that staff coordinated services with other disciplines for 2 of 11 patients (#16 and 17), who received care from more than one HHA discipline. Without communication between disciplines there is the potential for the appropriate discipline having the opportunity to resolve the problems associated with a	G 144	To ensure that Home Health services clinical records or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur, the following will take place: ▪ All SOC, evaluation and intervention visit forms for nursing, PT, OT, and ST will be revised to include documentation that the patient care was discussed with the appropriate discipline(s). **See attachment A.** ▪ At the beginning of each week all therapy contractors will fax their weekly calendar, list of any therapy discharges for the week and the names of patients with multiple disciplines involved to be discussed at patient care conference at next scheduled patient care conference. **See attachment B.** ▪ In preparation for patient care conference, therapy contractors will complete the team conference form on therapy only patients that includes a summary of their care. **See attachment C.**	8/01/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Mary LaTieure B.A. R.N Home Health Administrator 7/10/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 144	Continued From page 1 condition change. Findings include: *Patient #17 was a 10 year old male with SOC 7/9/07. His diagnoses included spastic quadriplegia, seizure disorder, pneumonia and chronic sinusitis. The patient had frequent hospitalizations. He received SN and PT services. Several PT visits were refused by the patient's mother. There was no documentation present in the record to indicate that there was regular communication between PT and SN concerning the patient's condition or concerning the refusal of PT visits. *Patient #16 was a 93 year old female with SOC 3/20/08. She received services from SN, OT and PT. There was no documentation in the record of Communication between these disciplines concerning the patient's condition. The patient had been hospitalized for a fall resulting in a shoulder fracture. On 6/4/08 the case manager confirmed the lack of communication between disciplines.	G 144	▪ Discussion at patient care conference will include: patients with multiple disciplines, those being recertified, falls, discharges; pending and actual, and any other patients that staff members wish to discuss ie., complex med changes, safety, non-adherence and family dynamic related issues. ▪ Following patient care conference, a completed team conference form will be given to the nurse case manager for review/signature. ▪ The following will be added to the monthly and quarterly chart audit tool and responsibility for this monitoring has been assigned to the OBQI Coordinator and nursing supervisors. **Look at team conference section, communication notes, visit notes: Is there evidence of communication between/among disciplines if the patient is receiving more than one skilled service? See attachments D,E.** ▪ The appropriate policies and procedures will be revised to address the outlined changes. **See attachments F,G, and H.** ▪ The above changes will be addressed with all nursing staff and therapy contractors. **See attachments I and J.**	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, or medicine, osteopathy, podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview it was determined that the HHA failed to ensure that patient care was delivered by HHA disciplines according to the POC approved by the doctor for 8 of 19 patients (#1, 7, 9, 11, 13, 16 ,17 and 18), whose records were reviewed for assessment of	G 158	To ensure that the agency follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine, the following will take place: ▪ Policy and procedures will be revised to accept visit ranges ie., 2-4 X/wk X 8 weeks and PRN visits may be requested as long as they are qualified. This change in practice will reduce the number of missed/extra visits. **See attachment K.** ▪ Technical Records Specialists will be responsible for reconciliation of visits with MD orders using the Sansio software system. If missed visits occur, the physician will be notified by	801/08

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G 158	Continued From page 2 POC. Failure to follow the prescribed POC could result in delay of the patients' progress toward their goals. Findings include: * Patient #1 was a 68 year old male with a SOC of 12/10/07. The patient's POC, dated 4/8/08, I documented that nursing staff was to see the patient as follows: 1 time for the first week 2 times for the second week 1 time for the third week The record contained only one nursing visit during week #2 on 4/22/08. The record contained no documented evidence that a second visit was conducted that week. The patient's record did not I contain a physician order for the fourth week starting 4/27/08. However, the nurse had seen the patient on 4/29 and 5/2/08. The patient's record did, however, contain an order dated 5/9/08 that stated, "Skilled nurse 1 more time this week, then 1 x wk x 2 wks, 2 x wk x 2 wks, then re eval [sic]." The week starting 5/18/08, there was no documented evidence the nurse had seen the patient, and the week beginning 5/25/08 the patient was only seen once. There was no documented evidence the physician had been notified of the missed or extra visits. On 6/3/08 at 3:40 PM, the case manager reviewed the patient's record and confirmed the extra and missed visits. * Patient #9 was a 61 year old male with a SOC of' 5/1/08. The patient's OT POC, dated 5/6/08, documented that OT was to see the patient as follows:	G 158	faxing a missed visit report. A copy of the fax confirmation will be kept in the patient record. **See attachment L.** * The following will be added to the monthly and quarterly chart audit tool and responsibility for this monitoring has been assigned to the OBQI Coordinator and nursing supervisors. ° Look at the missed visit reports, orders, communication notes: Is there evidence that MD, DO, or DPM has been notified of the missed visit? ° Look at the SOC, ROC, recertification, orders: If a prn visit is ordered, is there a specific reason for the visit noted? **See attachments D and E.** * The above changes will be reviewed with all nursing staff and therapy contractors. **See attachments I and J.**	

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G 158	Continued From page 3 Evaluation plus 2 times for the first week 3 times a week for 2 weeks 2 times a week for 4 weeks The record contained documentation of only two OT visits during week #3. The record contained no documented evidence that a third visit was conducted that week. There was no documented evidence the physician had been notified of the missed visit. On 6/3/08 at 4:00 PM, the case manager reviewed the patient's record and confirmed the missed visit. *Patient #11 was an 87 year old female with a SOC of 5/14/08. The patient's POC, dated 5/14/08, documented that SN was to see the patient 2 times a week for 4 weeks. The record contained only one nursing visit during the week of 5/18/08. The record contained no documented evidence that a second visit was conducted that week. There was no documented evidence the physician had been notified of the missed visit. On 6/3/08 at 4:10 PM, the case manager reviewed the patient's record and confirmed the missed visit. *Patient #7 was a 54 year old male with SOC 5/11/2008. His initial POC, dated 5/11/08, called I for four SN visits during the first week. Documentation showed visits on 5/11, 5/12 and 5/16/2008. There were only three SN visits done during the first week. No missed visit notes to the MD were documented. On 6/4/08 at 1:00 PM the case manager reviewed the record and confirmed the missed visit.	G 158		

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G 158	Continued From page 4 *Patient #16 was a 93 year old female with SOC of 3/20/08. She received services from SN, PT and OT. Her OT POC, dated 3/21/08, stated visits would be made two times a week for three weeks. The record contained documentation of only one OT visit during week #2, 3/30/08 - 4/5/08, instead of the prescribed two visits. There was a missed visit note in the patient's chart, written by the OT, with the explanation that the visit scheduled for 3/31/08 was missed because there were no OT services available that day. On 6/4/08 at 1:00 PM, the case manager reviewed the record and confirmed the missed visit. *Patient #13 was a 57 year old male with SOC 8/20/07. His POC, dated 4/15/08, showed OT visits to be done twice a week for one week then once a week for three weeks. OT visited the patient on 4/21 and 4/24/08. This was one extra, unordered visit for the week of 4/20/08. There was no documentation that this extra visit was ordered by or communicated to the physician. On 6/4/08 at 1:00 PM, the case manager reviewed the record and confirmed the extra visit. * Patient #17 was a 10 year old quadriplegic with SOC 7/9/07. A physician's order, dated 4/2/08, called for SN visits to occur every other week. SN visited on 4/17/08 but no visit was made during the week of 4/27/08. There was no documentation that the physician was notified of this missed visit. On 6/4/08 at 1:00 PM, the case manager reviewed the record and confirmed the missed	G 158		

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G 158	Continued From page 5 visit. *Patient #18 was a 91 year old patient with a SOC 4/2/08. The patient's PT POC, dated 4/23/08, called for visits two times a week for four weeks. There was no documentation showing visits on 4/25/08, 4/29/08 and 5/5/08. Only one visit was made during weeks one, two and three. There was only one visit made during the fourth week, 5/11 - 5/17/08. There was no documentation that the physician had been notified of these missed visits. On 6/4/08 at 1:00 PM, the case manager reviewed the record and confirmed the missed visits.	G 158		
G 332	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. This STANDARD is not met as evidenced by: Based on record review, patient interview and staff interview, it was determined that the HHA failed to ensure that initial assessment visits were done within 48 hours of referral for 3 of 19 patients, (#2, 4 and 16), whose records were reviewed for assessment of timely admission. This deficient practice could delay needed services and therapies to patients. Findings include: * Patient #2 was an 61 year old female who was referred to home health because of a joint replacement. The patient's clinical record included a physician's order dated 5/23/08 for Home Health. The patient's clinical record	G 332	To ensure that the initial assessment visit is held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date, the following will take place: ▪ Policy and procedures that pertain to the above will be reviewed with all nursing staff and therapy contractors. **See attachments I, J and N.** ▪ Nursing supervisors or RN Sr., will verify the status of pending referrals on a daily basis. Policies and procedures will be revised to reflect this accountability. **See attachment M.** ▪ The following will be added to the monthly and quarterly chart audit tool and responsibility for this monitoring has been assigned to the OBQI Coordinator and nursing supervisors. **Look at**	8/01/08

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G 332	Continued From page 6 contained a "Start or Resumption of Care" document dated 5/27/08, the date the nurse conducted the initial assessment. This was a span of 4 days from the physician's referral. The clinical record did not provide documented evidence that the physician was contacted to approve the delay in initial assessment and treatment. On 6/3/08 at 4:15 PM, the case manager reviewed the patient's record and could not explain why the SOC was on 5/27/08. On 6/5/08 at 8:45 AM, the patient was interviewed. She stated she was discharged from the hospital on 5/23/08. She said by 5/25/08 she had not heard from the HHA and called the discharge planner at the hospital to see why the HHA had not contacted her. She said she was told the referral was made and was given the phone number for the HHA. She called the HHA on 5/25/08 and left a message. She stated that on 5/27/08, the HHA returned her phone call and came out to her house. Patient #4 was an 87 year old female with SOC 2/17/08. A doctor's order for OT was obtained on 2/25/08. The initial visit for evaluation by OT was not made until 3/3/08. There was no documentation in the record as to why this visit was deferred. On 6/5/08 the Administrator confirmed that this initial visit was not made within 48 hours of referral order as required. Patient #16 was a 93 year old patient with SOC 3/20/08. She was hospitalized following a fall. She was discharged on 4/13/08. A physician's	G 332	**communication notes: Is there evidence that the communication note details the status of a pending referral if the patient's initial visit is not completed within 48 hours of referral? See attachments D and E.** ▪ The above changes will be reviewed with all nursing staff and therapy contractors. **See attachments I and J.**	

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G 332	Continued From page 7 order to resume care was dated 4/17/08. Her Resumption of Care visit was not done within the required 48 hours after referral. There was a communication note in the record from nursing that stated, "Admit deferred until 4/19 due to staff availability". Actual SN visit for evaluation and resumption of care was dated 4/20/08. On 6/5/08 the Administrator confirmed that the resumption was not done within the required time frame.	G 332		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FORM APPROVED
OMB NO. 0938-0391

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N 092	03.07024.01. SK.NSG.SERV. N092 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: This Rule is not met as evidenced by: Refer to G158 as it relates to the coordination of I services by skilled nursing.	N 092	To ensure that Home Health services clinical records or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur, the following will take place: ▪ All SOC, evaluation and intervention visit forms for nursing, PT, OT, and ST will be revised to include documentation that the patient care was discussed with the appropriate discipline(s). **See attachment A.** ▪ At the beginning of each week all therapy contractors will fax their weekly calendar, list of any therapy discharges for the week and the names of patients with multiple disciplines involved to be discussed at patient care conference at next scheduled patient care conference. **See attachment B.** ▪ In preparation for patient care conference, therapy contractors will complete the team conference form on therapy only patients that includes a summary of their care. **See attachment C.** ▪ Discussion at patient care conference will include: patients with multiple disciplines, those being recertified, falls, discharges; pending and actual, and any other patients that staff members wish to discuss ie., complex med changes, safety, non-adherence and family dynamic related issues. ▪ Following patient care conference, a completed team conference form will be given to the nurse case manager for review/signature. ▪ The following will be added to the monthly and quarterly chart audit tool and responsibility for this monitoring has been assigned to the OBQI Coordinator and nursing supervisors. **Look at team conference section, communication notes, visit notes: Is there evidence of communication between/among disciplines if the patient is receiving more than one skilled service? See attachments D,E.** ▪ The appropriate policies and procedures will be revised to address the outlined changes. **See attachments F,G, and H.** ▪ The above changes will be addressed with all nursing staff and therapy contractors. **See attachments I and J.**	
N 152	03.07030.01. PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to G 158 as it relates to the delivery of care	N 152	To ensure that the agency follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine, the following will take place: ▪ Policy and procedures will be revised to accept visit ranges ie., 2-4 X/wk X 8 weeks and PRN visits may be	

requested as long as they are qualified. This change in practice will reduce the number of missed/extra visits. **See attachment K.**

Technical Records Specialists will be responsible for reconciliation of visits with MD orders using the Sansio software system. If missed visits occur, the physician will be notified by faxing a missed visit report. A copy of the fax confirmation will be kept in the patient record. **See attachment L.**

- The following will be added to the monthly and quarterly chart audit tool and responsibility for this monitoring has been assigned to the OBQI Coordinator and nursing supervisors.
  - Look at the missed visit reports, orders, communication notes: Is there evidence that MD, DO, or DPM has been notified of the missed visit?
  - Look at the SOC, ROC, recertification, orders: If a prn visit is ordered, is there a specific reason for the visit noted? **See attachments D and E.**
- The above changes will be reviewed with all nursing staff and therapy contractors. **See attachments I and J.**